DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 28, 2020

Administrator
Good Samaritan Society - Woodland
100 Buffalo Hills Lane
Brainerd, MN 56401

RE: CCN: 245488
Cycle Start Date: July 24, 2020

Dear Administrator:

On August 5, 2020, we notified you a remedy was imposed. On August 26, 2020 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of August 17, 2020.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective August 22, 2020 did not go into effect. (42 CFR 488.417 (b))

In our letter of August 5, 2020, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 22, 2020 due to denial of payment for new admissions. Since your facility attained substantial compliance on August 17, 2020, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Electronically delivered

September 28, 2020

Administrator
Good Samaritan Society - Woodland
100 Buffalo Hills Lane
Brainerd, MN 56401

Re: Reinspection Results
Event ID: 7IIR12

Dear Administrator:

On August 26, 2020 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on July 24, 2020. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Electronically delivered
August 7, 2020

Administrator
Good Samaritan Society - Woodland
100 Buffalo Hills Lane
Brainerd, MN 56401

RE: CCN: 245488
Cycle Start Date: July 24, 2020

Dear Administrator:

On July 24, 2020, a survey was completed at your facility by the Minnesota Departments of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 22, 2020.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective August 22, 2020. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 22, 2020.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

• Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $10,483; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by August 22, 2020, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Good Samaritan Society - Woodland will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 22, 2020. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.
However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.

- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Lyla Burkman, Unit Supervisor
Email: lyla.burkman@state.mn.us
Phone: (218) 308-2104
Fax: (218) 308-2122

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 24, 2021 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245488	A. BUILDING _____ B. WING _____	C 07/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WOODLAND	**100 BUFFALO HILLS LANE BRAINERD, MN 56401**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 7/23/20 and 7/24/20, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be substantiated: H5488020C: Deficiency issued at F689 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	Past noncompliance: no plan of correction required.	
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 689		8/17/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 08/17/2020

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F 689	Continued From page 1 Based on interview and document review, the facility failed to implement care planned interventions to reduce the risk of falls for 1 of 3 residents (R1) reviewed for falls. This resulted in actual harm when R1 fell from a shower chair resulting in lacerations to her forehead, lip and knee. In addition, the facility failed to thoroughly assess for the root and identify a pattern of falls and failed to implement interventions for 1 of 3 residents (R3) reviewed for falls. Findings include: R1's quarterly Minimum Data Set (MDS) dated 4/27/20, indicated she was severely cognitively impaired, required extensive assistance from two staff for bed mobility, transfers and toileting and total assistance from one staff for bathing. The MDS indicated R1 had no falls since the previous assessment. R1's Falls Care Area Assessment (CAA) dated 11/7/19, indicated she had difficulty maintaining sitting balance and had impaired balance during transfers. The CAA further identified poor insight and no safety awareness and R1 remained at risk for falling. R1's Care Plan dated 5/12/20, indicated a self care deficit and directed staff to provide whirlpool baths due to fall risk. The care plan was updated 7/21/20, to include, could have showers with safety belt. The care plan was revised on 7/23/20, to include staff to provide bathing assistance and indicated tub or bed bath for safety. The care plan further identified a risk for falls related to a history of putting herself on the floor to look for things, impaired mobility and impaired cognition and directed the use of a tilt in space wheel chair, Dycem in recliner, a wheel chair and a low bed.	F 689	1. Resident 1's injuries treated in emergency department. Therapy assessed resident on 7/29 to determine proper shower chair positioning. Care plan interventions to reduce the risk of falls was reviewed and care plan updated. Employee suspended pending investigation at time of incident of R1. Employee received re-education on safety precautions and bathing assistance before return. Resident #3 had a toileting assessment completed on 6/11/20, no changes needed at time. Toileting assessment completed on 6/18/20 and care plan updated. Toileting assessment completed on 6/25/20. Care plan reviewed and no changes needed. Root cause analysis completed on 8/11/20. Bladder assessment incontinence data collection tool being completed on 8/14/20. Care plan updated with new program assessment recommendations. Medication review completed on 8/13/20 by consultant pharmacist. Medication suggestions sent to MD on 8/14/20 awaiting MD decision for implementation. 2. All shower chair assisted bathing was suspended until staff had education on policy and procedure and safety device use. All residents fall interventions relating to bathing assistance via shower chair were reviewed and care plans updated as needed. All residents' interventions to reduce the risk of falls were reviewed and any changes needed were care planned. A reclining shower was purchased on	

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F 689	Continued From page 2 A nursing assistant (NA) care guide (Kardex) dated 7/19/20, indicated R1 required assistance from one staff for bathing and she could receive a shower with the safety belt on the shower chair for safety. On 7/23/20, at 9:56 a.m. R1 was observed seated in a tilt in space wheelchair in her room. R1's face was noted to have red/purple bruising around her eyes and forehead extending into her hairline. A cut was also noted on her upper lip. A facility incident report dated 7/20/20, indicated R1 was receiving a shower when she fell from the shower chair. NA-A called for help and writer entered the shower room to find R1 on the floor. R1 was lying on the floor on her right side with blood coming from her forehead, top lip and right knee. R1 complained of her head hurting. A facility Progress Note dated 7/20/20, indicated R1 fell out of the shower chair at 5:10 p.m. She was found to have a laceration on her forehead, laceration on right knee and a bruise and laceration on her upper lip. R1 was transferred to the hospital. Progress Note dated 7/21/20, indicated the interdisciplinary team (IDT) met to review R1's fall. While in the shower chair, staff turned away and R1 fell forward from the shower chair. R1 was care planned to have a seat belt on while in the chair and staff had not put the belt on. A facility document titled Investigation Interview dated 7/20/20, indicated NA-B stated the brakes and the PVC pipe on the shower chair were loose.	F 689	7/22/20. Residents noted to be at risk for frequent falls were reviewed to ensure appropriate root cause had identified and care planned interventions. 3. All staff re-educated on “Bathing nursing services” and “Restraints” policy and procedures. All staff that give bathing assistance were determined to be competent by completing the clinical skill checklist prior to providing this assistance. All staff to have reeducation on 8/20 and 8/21 on finding care plan interventions via Kardex. Licensed nursing staff to be reeducated on proper care planning tools to pull interventions to the care plan. All staff will be reeducated on proper bathing positioning and who to notify of any change in condition making assistance no longer appropriate for reassessment. IDT was reeducated on the safety incident management tool and its use to complete a root cause after each fall. Nursing staff to be educated on Fall policy and procedures and close calls. 4. Random audits during bathing times will be completed by QAPI coordinator or designee, five times/week for 4 weeks at various times to ensure care plan interventions are being followed. Random audits will occur 2 times/week for 4 weeks and then 1 time/week for 4 weeks. Results will be forwarded to the QAPI committee for further recommendation.	

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F 689	Continued From page 3 NA-C's Investigation Interview dated 7/20/20, indicated she did not know how to use the shower chair and indicated she had not been trained on who needed a safety belt while in the chair. NA-A further stated the brakes on the shower chair did not work very well. NA-D's Investigation Interview dated 7/20/20, indicated she had not received training regarding the use of seat belts on the shower chair. Licensed practical nurse (LPN)-A's Investigation Interview indicated she was not aware R1 required the use of a seat belt when seated in the shower chair. During interview on 7/24/20, at 9:51 a.m. the maintenance director (MD) was observed in the facility shower room inspecting the shower chairs. The MD stated prior to R1's fall in the tub room, no regular inspections of the shower chairs had been completed and stated they were only inspected if someone reported an issue. The MD stated since R1's fall, routine safety inspections of the bathing equipment had been integrated into the buildings maintenance management system. Upon inspection of the shower chairs, the maintenance director removed one of three shower chairs from the tub room and stated the chair had loose PVC pipes and no safety seatbelt. At 10:15 a.m. the director of nursing (DON) stated R1 had always been a fall risk and had sustained multiple falls in the past. The DON stated R1 had a previous fall out of the shower chair which was when the seat belt in the shower chair was initiated. The DON stated while investigating R1's recent fall, it was determined staff were not aware of the need to use the seat	F 689	Audit will be completed on every fall to ensure GSS 409 and 415 were completed as a team and any information to help determine root cause is noted. It will also ensure that review was completed in the safety incident management tool to ensure interventions are appropriate to reduce the risk of injury or serious harm. 5. Date of Compliance: August 22, 2020	

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F 689	Continued From page 4	F 689		

belts when a resident was seated in the shower chairs. At that time, the DON said the facility had directed staff not to use the shower chairs, provided education on the the policies and procedures and initiated a return demonstration training to be completed before the staff could use a shower chair again. The DON stated staff that had not completed the return demonstration could only use the whirlpool. She stated NA-C received training prior to returning to work following the incident.

During interview on 7/24/20, at 11:02 a.m. NA-C stated she was not aware R1 needed a lap (seat) belt while in the shower chair. NA-A stated during training, she was only trained on using the whirlpool and had not received training on the use of the shower chairs. NA-C said at the start of the shift staff only got a list of who was scheduled to receive a bath and what type of bath they were to receive. When asked about the use of the Kardex, NA-C stated, "I actually don't know where the Kardex is." NA-C stated prior to returning to work she was required to review the policies and procedures related to bathing and had not been allowed to give showers until the new shower chairs were obtained.
R3's admission MDS dated 5/26/20, indicated R3's diagnoses included urinary tract infection, acute kidney failure, diabetes mellitus, dementia, difficulty walking, weakness and history of falling. The MDS also indicated R3 had short and long term memory impairment, impaired decision making, and displayed no psychosis, physical, verbal or other behavior symptoms, rejection of care or wandering and required limited assistance with all mobility and extensive assistance with toileting.

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F 689	Continued From page 5	F 689		

R3's Cognitive CAA dated 6/02/20, indicated R3 had memory impairment and dementia which affected day to day tasks and created a fall risk due to R3 self transferring and forgetting his limitations. R3's Urinary Incontinence and Indwelling Catheter CAA dated 6/02/20, indicated R3 was incontinent of bladder daily and was inconsistent with recognizing his own toileting needs, even when wet.

R3's Care Plan dated 5/21/20, with revision date of 6/21/20, indicated a high risk for falls related to impaired mobility, weakness and history of falls. The Care Plan indicated R3 self transferred, had no idea of his limitations, did not use his call light and would often refuse assistance with cares. The care plan indicated due to the self transfers, R3 had numerous falls, but indicated further physical interventions were felt to be too restrictive and could cause more harm than good. The care plan directed staff to continue to make attempts to keep R3 safe and reduce falls. Staff were directed to remind R3 not to bend over to pick up dropped items, encourage to participate in activities that promoted exercise and ensure R3 was wearing proper foot wear and gripper socks when in bed. The care plan further directed staff to place pancake button on R3's bed, non-skid strips on floor in front of the toilet and to monitor R3 hourly.

Review of R3's clinical record revealed the following:

-Incident report dated 6/9/20, at 10:41 p.m. R3 was found lying on the bathroom floor with his pants down. R3 stated he must have fallen. No injury. Intervention: gripper socks on at all times and non-skid strips to R3's bathroom floor.

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F 689	Continued From page 6	F 689		

-Incident report dated 6/13/20, at 2:00 a.m. R3 was anxious and trying to get out of bed, but refused staff assistance. Staff accompanied R3 to walk in the hall. R3 was ambulated back to bed and while staff was straightening his bed, R3 lost his balance and fell backwards. R3 was wearing gripper socks and had a gait belt on. No injuries. Interventions: pancake button placed on bed to alert staff of any attempts R3 made to get out of bed and staff to monitor R3 hourly.

-Incident report dated 6/19/20, at 7:30 p.m. R3 was found lying on the floor in his room. R3 had gripper socks on and his call light and pancake light had alerted. R3 stated he was going to the bathroom. No injuries. No interventions were identified. The Care Plan was updated for R3 to remain free from injury of falls. R3 was mobile, impulsive and independent minded. Physical therapy was at max baseline, other material interventions felt to be invasive and would cause more distress than good.

-Incident report dated 7/17/20, at 2:50 p.m. R3 was found lying on the bathroom floor. R3 stated he was trying to get to the restroom and lost his balance. No injuries. No interventions identified.

R3's clinical record lacked comprehensive assessments and identified interventions to address the falls which occurred on 6/19/20 and 7/17/20.

On 7/23/20, at 11:22 a.m. RN-A was observed to enter R3's room following his request to go to the bathroom. RN-A was unable to locate a gait belt in the room and so exited the room to find one. R3 stated she will be gone a half hour or more,

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	245488	A. BUILDING _____ B. WING _____	C 07/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WOODLAND	**100 BUFFALO HILLS LANE BRAINERD, MN 56401**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 7	F 689		

they always say a couple of seconds but it ends up to be a long time, and when you have to go to the bathroom, you just can't wait that long. RN-A returned and started to assist R3 to the bathroom and with hand hygiene.
-At 11:58 a.m. a dietary aide (DA)-A was observed to enter R3's room and was overheard to offer to take him into the dining room for his noon meal. R3 replied he had to go to the bathroom first. DA-A left the room without reply.
-At 12:01 p.m. NA-A knocked on R3's door and looked into the room and then left.
-At 12:02 p.m. R3 was observed to have transferred himself onto the toilet in his bathroom. NA-A was requested to assist R3. NA-A entered the room and after washing his hands and gloving, assisted R3 with toileting and hand hygiene.
-At 12:05 p.m. DA-A confirmed R3 had requested to go to the bathroom and verified he had not informed nursing staff of R3's request.

On 7/24/20, at 9:36 a.m. R3 was observed wheeling himself back to his room following breakfast in the dining room.

-At 9:41 R3 was observed to have self transferred himself to the toilet in his bathroom. RN-B was asked to assist R3 in the bathroom. RN-B confirmed R3 was not safe to transfer alone and called for an aide to assist R3 but was informed the aides were all occupied assisting other residents. RN-B entered R3's bathroom to assist him with completing his toileting however, R3 stated he would need more time. RN-B handed R3 his bathroom pull cord and instructed R3 to ring for assistance when he was finished. RN-B then left the room.

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-At 9:46 a.m. NA-A entered R3's room and after washing his hands and applying gloves, assisted R3 to complete toileting and hand hygiene. NA-A stated the staff tried to check on R3 as frequently as they could, but the call lights were exceptionally busy that morning. NA-A stated, "We are doing the best we can." NA-A stated he thought R3 was on two hour checks but that he would have to check R3's Kardex and plan of care to be sure. NA-A checked R3's Kardex and stated R3 was to be toileted every two hours and was on hourly monitoring. NA-A stated the aides had to document each check they performed on the Kardex to record they were doing them.

-At 9:50 a.m. NA-B stated she would look on the Kardex to see what each resident needed and how they were to transfer. She stated she could not think of anyone on a specific toileting program and that they pretty much toileted every resident every two hours.

-At 10:00 a.m. RN-B stated they add an intervention after each fall and if that did not work they would add another one and another one and so on. RN-B stated the interventions were chosen based on how the resident fell, such as if someone rolled out of bed, they would add a fall mat. RN-B stated a fall mat would not work with R3. After reviewing all of R3's falls since admission, RN-B confirmed all but one fall involved toileting and stated she did feel a toileting schedule may be an appropriate intervention for R3.

-At 10:50 a.m. the DON stated R3 had a history of falls at his previous facility as well as when he was at home. The DON stated he was just a frequent faller, had received therapy, but

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continued to transfer independently, did not use the call light appropriately and did not ask for assistance. The DON stated R3 was on an every two hour toileting schedule however, they had not looked at his toileting needs that closely. The DON confirmed a more specific toileting schedule tailored to R3's needs, may prevent some falls. In addition, the DON confirmed that the dietary staff should have notified nursing of R3's request and had been educated on what to do in the future.

-At 1:29 p.m. the DON confirmed that while a bowel and bladder assessment had been completed on 6/3/20, following admission, another assessment was not initiated in order to identify a potential relationship between R3's toileting needs and falls.

The facility Fall Prevention and Management policy, dated 6/24/20, identified five purposes which included: to promote resident well-being by developing and implementing a fall prevention and management program and to identify risk factors and implement interventions before a fall occurred. The policy defined root cause analysis as a method for identifying the causes of the problem so that the best solutions could be identified and put into place. The policy directed staff to review admission documentation for fall risk factors and to care plan the appropriate interventions, including personalizing all areas.

Electronically delivered
August 7, 2020

Administrator
Good Samaritan Society - Woodland
100 Buffalo Hills Lane
Brainerd, MN 56401

Re: State Nursing Home Licensing Orders
Event ID: 7IIR11

Dear Administrator:

The above facility was surveyed on July 23, 2020 through July 24, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the

"Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Lyla Burkman, Unit Supervisor
Email: lyla.burkman@state.mn.us
Phone: (218) 308-2104
Fax: (218) 308-2122

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00956	A. BUILDING: _____ B. WING _____	C 07/24/2020

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 7/23/20 and 7/24/20, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found NOT to be in compliance with the MN State Licensure. The following complaint found to be substantiated with a licensing order issued:	2 000		

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2 000	Continued From page 1 H5488020C The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the	2 000		

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2 000	Continued From page 2 findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to implement care planned interventions to reduce the risk of falls for 1 of 3	2 830	1. Resident 1's injuries treated in emergency department. Therapy assessed resident on 7/29 to determine	8/17/20

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2 830	Continued From page 3	2 830		

residents (R1) reviewed for falls. This resulted in actual harm when R1 fell from a shower chair resulting in lacerations to her forehead, lip and knee. In addition, the facility failed to thoroughly assess for the root and identify a pattern of falls and failed to implement interventions for 1 of 3 residents (R3) reviewed for falls.

Findings include:

R1's quarterly Minimum Data Set (MDS) dated 4/27/20, indicated she was severely cognitively impaired, required extensive assistance from two staff for bed mobility, transfers and toileting and total assistance from one staff for bathing. The MDS indicated R1 had no falls since the previous assessment. R1's Falls Care Area Assessment (CAA) dated 11/7/19, indicated she had difficulty maintaining sitting balance and had impaired balance during transfers. The CAA further identified poor insight and no safety awareness and R1 remained at risk for falling.

R1's Care Plan dated 5/12/20, indicated a self care deficit and directed staff to provide whirlpool baths due to fall risk. The care plan was updated 7/21/20, to include, could have showers with safety belt. The care plan was revised on 7/23/20, to include staff to provide bathing assistance and indicated tub or bed bath for safety. The care plan further identified a risk for falls related to a history of putting herself on the floor to look for things, impaired mobility and impaired cognition and directed the use of a tilt in space wheel chair, Dycem in recliner, a wheel chair and a low bed.

A nursing assistant (NA) care guide (Kardex) dated 7/19/20, indicated R1 required assistance from one staff for bathing and she could receive a shower with the safety belt on the shower chair

proper shower chair positioning. Care plan interventions to reduce the risk of falls was reviewed and care plan updated. Employee suspended pending investigation at time of incident of R1. Employee received re-education on safety precautions and bathing assistance before return.

Resident #3 had a toileting assessment completed on 6/11/20, no changes needed at time. Toileting assessment completed on 6/18/20 and care plan updated. Toileting assessment completed on 6/25/20. Care plan reviewed and no changes needed. Root cause analysis completed on 8/11/20. Bladder assessment incontinence data collection tool being completed on 8/14/20. Care plan updated with new program assessment recommendations. Medication review completed on 8/13/20 by consultant pharmacist. Medication suggestions sent to MD on 8/14/20 awaiting MD decision for implementation.

2. All shower chair assisted bathing was suspended until staff had education on policy and procedure and safety device use. All residents fall interventions relating to bathing assistance via shower chair were reviewed and care plans updated as needed. All residents' interventions to reduce the risk of falls were reviewed and any changes needed were care planned. A reclining shower was purchased on 7/22/20.

Residents noted to be at risk for frequent falls were reviewed to ensure appropriate

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2 830	Continued From page 4 for safety. On 7/23/20, at 9:56 a.m. R1 was observed seated in a tilt in space wheelchair in her room. R1's face was noted to have red/purple bruising around her eyes and forehead extending into her hairline. A cut was also noted on her upper lip. A facility incident report dated 7/20/20, indicated R1 was receiving a shower when she fell from the shower chair. NA-A called for help and writer entered the shower room to find R1 on the floor. R1 was lying on the floor on her right side with blood coming from her forehead, top lip and right knee. R1 complained of her head hurting. A facility Progress Note dated 7/20/20, indicated R1 fell out of the shower chair at 5:10 p.m. She was found to have a laceration on her forehead, laceration on right knee and a bruise and laceration on her upper lip. R1 was transferred to the hospital. Progress Note dated 7/21/20, indicated the interdisciplinary team (IDT) met to review R1's fall. While in the shower chair, staff turned away and R1 fell forward from the shower chair. R1 was care planned to have a seat belt on while in the chair and staff had not put the belt on. A facility document titled Investigation Interview dated 7/20/20, indicated NA-B stated the brakes and the PVC pipe on the shower chair were loose. NA-C's Investigation Interview dated 7/20/20, indicated she did not know how to use the shower chair and indicated she had not been trained on who needed a safety belt while in the chair. NA-A further stated the brakes on the shower chair did	2 830	root cause had identified and care planned interventions. 3. All staff re-educated on “Bathing nursing services” and “Restraints” policy and procedures. All staff that give bathing assistance were determined to be competent by completing the clinical skill checklist prior to providing this assistance. All staff to have reeducation on 8/20 and 8/21 on finding care plan interventions via Kardex. Licensed nursing staff to be reeducated on proper care planning tools to pull interventions to the care plan. All staff will be reeducated on proper bathing positioning and who to notify of any change in condition making assistance no longer appropriate for reassessment. IDT was reeducated on the safety incident management tool and its use to complete a root cause after each fall. Nursing staff to be educated on Fall policy and procedures and close calls. 4. Random audits during bathing times will be completed by QAPI coordinator or designee, five times/week for 4 weeks at various times to ensure care plan interventions are being followed. Random audits will occur 2 times/week for 4 weeks and then 1 time/week for 4 weeks. Results will be forwarded to the QAPI committee for further recommendation. Audit will be completed on every fall to ensure GSS 409 and 415 were completed as a team and any information to help determine root cause is noted. It will also ensure that review was completed in the	

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2 830	Continued From page 5 not work very well. NA-D's Investigation Interview dated 7/20/20, indicated she had not received training regarding the use of seat belts on the shower chair. Licensed practical nurse (LPN)-A's Investigation Interview indicated she was not aware R1 required the use of a seat belt when seated in the shower chair. During interview on 7/24/20, at 9:51 a.m. the maintenance director (MD) was observed in the facility shower room inspecting the shower chairs. The MD stated prior to R1's fall in the tub room, no regular inspections of the shower chairs had been completed and stated they were only inspected if someone reported an issue. The MD stated since R1's fall, routine safety inspections of the bathing equipment had been integrated into the buildings maintenance management system. Upon inspection of the shower chairs, the maintenance director removed one of three shower chairs from the tub room and stated the chair had loose PVC pipes and no safety seatbelt. At 10:15 a.m. the director of nursing (DON) stated R1 had always been a fall risk and had sustained multiple falls in the past. The DON stated R1 had a previous fall out of the shower chair which was when the seat belt in the shower chair was initiated. The DON stated while investigating R1's recent fall, it was determined staff were not aware of the need to use the seat belts when a resident was seated in the shower chairs. At that time, the DON said the facility had directed staff not to use the shower chairs, provided education on the the policies and procedures and initiated a return demonstration training to be completed before the staff could	2 830	safety incident management tool to ensure interventions are appropriate to reduce the risk of injury or serious harm. 5. Date of Compliance: August 22, 2020	

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2 830	Continued From page 6	2 830		

use a shower chair again. The DON stated staff that had not completed the return demonstration could only use the whirlpool. She stated NA-C received training prior to returning to work following the incident.

During interview on 7/24/20, at 11:02 a.m. NA-C stated she was not aware R1 needed a lap (seat) belt while in the shower chair. NA-A stated during training, she was only trained on using the whirlpool and had not received training on the use of the shower chairs. NA-C said at the start of the shift staff only got a list of who was scheduled to receive a bath and what type of bath they were to receive. When asked about the use of the Kardex, NA-C stated, "I actually don't know where the Kardex is." NA-C stated prior to returning to work she was required to review the policies and procedures related to bathing and had not been allowed to give showers until the new shower chairs were obtained.

R3's admission MDS dated 5/26/20, indicated R3's diagnoses included urinary tract infection, acute kidney failure, diabetes mellitus, dementia, difficulty walking, weakness and history of falling. The MDS also indicated R3 had short and long term memory impairment, impaired decision making, and displayed no psychosis, physical, verbal or other behavior symptoms, rejection of care or wandering and required limited assistance with all mobility and extensive assistance with toileting.

R3's Cognitive CAA dated 6/02/20, indicated R3 had memory impairment and dementia which affected day to day tasks and created a fall risk due to R3 self transferring and forgetting his limitations. R3's Urinary Incontinence and Indwelling Catheter CAA dated 6/02/20, indicated

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	00956	A. BUILDING: _____ B. WING _____	C 07/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WOODLAND	100 BUFFALO HILLS LANE BRAINERD, MN 56401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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R3 was incontinent of bladder daily and was inconsistent with recognizing his own toileting needs, even when wet.

R3's Care Plan dated 5/21/20, with revision date of 6/21/20, indicated a high risk for falls related to impaired mobility, weakness and history of falls. The Care Plan indicated R3 self transferred, had no idea of his limitations, did not use his call light and would often refuse assistance with cares. The care plan indicated due to the self transfers, R3 had numerous falls, but indicated further physical interventions were felt to be too restrictive and could cause more harm than good. The care plan directed staff to continue to make attempts to keep R3 safe and reduce falls. Staff were directed to remind R3 not to bend over to pick up dropped items, encourage to participate in activities that promoted exercise and ensure R3 was wearing proper foot wear and gripper socks when in bed. The care plan further directed staff to place pancake button on R3's bed, non-skid strips on floor in front of the toilet and to monitor R3 hourly.

Review of R3's clinical record revealed the following:

-Incident report dated 6/9/20, at 10:41 p.m. R3 was found lying on the bathroom floor with his pants down. R3 stated he must have fallen. No injury. Intervention: gripper socks on at all times and non-skid strips to R3's bathroom floor.

-Incident report dated 6/13/20, at 2:00 a.m. R3 was anxious and trying to get out of bed, but refused staff assistance. Staff accompanied R3 to walk in the hall. R3 was ambulated back to bed and while staff was straightening his bed, R3 lost his balance and fell backwards. R3 was

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wearing gripper socks and had a gait belt on. No injuries. Interventions: pancake button placed on bed to alert staff of any attempts R3 made to get out of bed and staff to monitor R3 hourly.

-Incident report dated 6/19/20, at 7:30 p.m. R3 was found lying on the floor in his room. R3 had gripper socks on and his call light and pancake light had alerted. R3 stated he was going to the bathroom. No injuries. No interventions were identified. The Care Plan was updated for R3 to remain free from injury of falls. R3 was mobile, impulsive and independent minded. Physical therapy was at max baseline, other material interventions felt to be invasive and would cause more distress than good.

-Incident report dated 7/17/20, at 2:50 p.m. R3 was found lying on the bathroom floor. R3 stated he was trying to get to the restroom and lost his balance. No injuries. No interventions identified.

R3's clinical record lacked comprehensive assessments and identified interventions to address the falls which occurred on 6/19/20 and 7/17/20.

On 7/23/20, at 11:22 a.m. RN-A was observed to enter R3's room following his request to go to the bathroom. RN-A was unable to locate a gait belt in the room and so exited the room to find one. R3 stated she will be gone a half hour or more, they always say a couple of seconds but it ends up to be a long time, and when you have to go to the bathroom, you just can't wait that long. RN-A returned and started to assist R3 to the bathroom and with hand hygiene.
-At 11:58 a.m. a dietary aide (DA)-A was observed to enter R3's room and was overheard to offer to take him into the dining room for his

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noon meal. R3 replied he had to go to the bathroom first. DA-A left the room without reply.
-At 12:01 p.m. NA-A knocked on R3's door and looked into the room and then left.
-At 12:02 p.m. R3 was observed to have transferred himself onto the toilet in his bathroom. NA-A was requested to assist R3. NA-A entered the room and after washing his hands and gloving, assisted R3 with toileting and hand hygiene.
-At 12:05 p.m. DA-A confirmed R3 had requested to go to the bathroom and verified he had not informed nursing staff of R3's request.

On 7/24/20, at 9:36 a.m. R3 was observed wheeling himself back to his room following breakfast in the dining room.

-At 9:41 R3 was observed to have self transferred himself to the toilet in his bathroom. RN-B was asked to assist R3 in the bathroom. RN-B confirmed R3 was not safe to transfer alone and called for an aide to assist R3 but was informed the aides were all occupied assisting other residents. RN-B entered R3's bathroom to assist him with completing his toileting however, R3 stated he would need more time. RN-B handed R3 his bathroom pull cord and instructed R3 to ring for assistance when he was finished. RN-B then left the room.

-At 9:46 a.m. NA-A entered R3's room and after washing his hands and applying gloves, assisted R3 to complete toileting and hand hygiene. NA-A stated the staff tried to check on R3 as frequently as they could, but the call lights were exceptionally busy that morning. NA-A stated, "We are doing the best we can." NA-A stated he thought R3 was on two hour checks but that he would have to check R3's Kardex and plan of

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care to be sure. NA-A checked R3's Kardex and stated R3 was to be toileted every two hours and was on hourly monitoring. NA-A stated the aides had to document each check they performed on the Kardex to record they were doing them.

-At 9:50 a.m. NA-B stated she would look on the Kardex to see what each resident needed and how they were to transfer. She stated she could not think of anyone on a specific toileting program and that they pretty much toileted every resident every two hours.

-At 10:00 a.m. RN-B stated they add an intervention after each fall and if that did not work they would add another one and another one and so on. RN-B stated the interventions were chosen based on how the resident fell, such as if someone rolled out of bed, they would add a fall mat. RN-B stated a fall mat would not work with R3. After reviewing all of R3's falls since admission, RN-B confirmed all but one fall involved toileting and stated she did feel a toileting schedule may be an appropriate intervention for R3.

-At 10:50 a.m. the DON stated R3 had a history of falls at his previous facility as well as when he was at home. The DON stated he was just a frequent faller, had received therapy, but continued to transfer independently, did not use the call light appropriately and did not ask for assistance. The DON stated R3 was on an every two hour toileting schedule however, they had not looked at his toileting needs that closely. The DON confirmed a more specific toileting schedule tailored to R3's needs, may prevent some falls. In addition, the DON confirmed that the dietary staff should have notified nursing of R3's request and had been educated on what to do in the

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2 830	Continued From page 11 future. -At 1:29 p.m. the DON confirmed that while a bowel and bladder assessment had been completed on 6/3/20, following admission, another assessment was not initiated in order to identify a potential relationship between R3's toileting needs and falls. The facility Fall Prevention and Management policy, dated 6/24/20, identified five purposes which included: to promote resident well-being by developing and implementing a fall prevention and management program and to identify risk factors and implement interventions before a fall occurred. The policy defined root cause analysis as a method for identifying the causes of the problem so that the best solutions could be identified and put into place. The policy directed staff to review admission documentation for fall risk factors and to care plan the appropriate interventions, including personalizing all areas. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and/or revise policies and procedures related to falls and the implementation of fall interventions, educate all appropriate staff. The DON or designee could develop monitoring systems to ensure ongoing compliance and present results to the quality assurance group for further recommendations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		